Advanced ICD 10 CM Documentation for Physicians
Objectives

- ICD 9 CM vs ICD 10 CM
- ICD 10 CM code structure
- Chapter Specific Tips
- What can you do now?
ICD 10 CM vs ICD 9 CM

- Many rules, guidelines and codes are the same and coding will carry on just as before
- Affects
  - facilitates’ reimbursement and revenue cycle
  - as well as enable tracking of services and ultimate decisions
- So accuracy is important

Can only be as accurate as the documentation
ICD 10 CM vs ICD 9 CM

- Codes may be 4, 5, 6, or 7 characters in length
- Final character may be a letter or a number
- The letters “O” & “I” are used; do not confuse with “0” & “1”
- 7th Character - Extensions
  - A = initial encounter
  - D = subsequent encounter
  - S = sequela (late effect)
ICD 10 CM vs ICD 9 CM

Initial encounter ("A"): initial encounter –
- the period when a patient is receiving active treatment
- may be assigned on more than one claim.
- Example: a patient seen in the ED for a head injury that first is evaluated by an ED physician.
- If the ED physician requests a CT scan that subsequently is read by a radiologist and a neurologist, the seventh character “A” is used by all three physicians and also reported on the ED claim.
- If the patient required admission to an acute-care hospital, the seventh character would be reported for the entire acute-care hospital stay because “A” is used for the entire period when the patient receives active treatment.
ICD 10 CM vs ICD 9 CM

Subsequent encounter ("D")

- this is an encounter occurring after the active phase of treatment, when a patient is receiving routine care during a period of healing or recovery.
- Example: a patient with an ankle sprain may return to the office to have joint stability re-evaluated to ensure that the injury is healing properly.
- In this case, the seventh character “D” would be assigned
Sequela ("S")

- for complications or conditions that arise as a direct result of an injury, such as scar formation after a burn.
- When reporting extension S, use both the injury code that precipitated the sequela and the code for the sequela itself.
- add the S only to the injury code, not the sequela code. The S extension identifies the injury responsible for the sequela.

ICD 10 CM vs ICD 9 CM
ICD 10 CM vs ICD 9 CM

For the Codes with 7\textsuperscript{th} Character

- Dummy placeholder “x” used

- Used in the 5th character position for some 6 or 7 character codes –“Holds" the position for future expansion without disrupting the 6 digit code structure

- A “filler" digit with no coding related meaning associated with it
ICD 10 CM vs ICD 9 CM

Dummy placeholder “x” used

- Examples:
- Crushing injury of larynx and trachea. initial encounter

S17.0XXA,
ICD 10 CM vs ICD 9 CM

Laterality

• Added laterality (indicate right side versus left side. Also codes available for unspecified “sides)
  – Example:
    • C50.212, Malignant neoplasm of upper-inner quadrant of left female breast
    • H02.835, Dermatochalasis of left lower eyelid
    • I80.01, Phlebitis and thrombophlebitis of superficial vessels of right lower extremity
Top Documentation Issues

- Expanded anatomy, specificity and laterality
- Extensive code categories that combine underlying cause with manifestations/complications for many acute & chronic diseases
- Increased numbers of codes that identify both infective cause/agent and the specific state of the infectious disease diagnosis
- Need to link timing & circumstance for injury and treatment in order to identify the episode of care as initial, subsequent or for sequel of failed treatment
ICD 10 CM Documentation
Chapter Specifics

Chapter 1 Infectious and parasitic diseases A00 – B99

• Use additional code for any associated drug resistance (Z16)
• Z16 Infection with drug resistant microorganisms
  – Code first the infection

Underlying condition and manifestations (use of fourth or fifth characters allowing the infectious disease & manifestation to be captured in one code instead of two)

Causal relationship required
ICD 10 CM Documentation
Chapter Specifics

Chapter 1 Infectious and parasitic diseases A00 – B99

• Example: A01.0 Typhoid fever Infection due to Salmonella typhi
  – A01.00, Typhoid fever, unspecified
  – A01.01, Typhoid meningitis
  – A01.02, Typhoid fever with heart involvement
  – A01.03, Typhoid pneumonia
  – A01.04, Typhoid arthritis
  – A01.05, Typhoid osteomyelitis
  – A01.09, Typhoid fever with other complications
ICD 10 CM Documentation
Chapter Specifics

Chapter 1 Infectious and parasitic diseases A00 – B99

• Example: A01.0 Typhoid fever Infection due to Salmonella typhi
  – A01.00, Typhoid fever, unspecified
  – A01.01, Typhoid meningitis
  – A01.02, Typhoid fever with heart involvement
  – A01.03, Typhoid pneumonia
  – A01.04, Typhoid arthritis
  – A01.05, Typhoid osteomyelitis
  – A01.09, Typhoid fever with other complications

Documentation Example: Patient developed a rhythm disturbance due to Salmonella typhimurium
  – A01.05, Typhoid osteomyelitis
  – A01.09, Typhoid fever with other complications
ICD 10 CM Documentation
Chapter Specifics

Chapter 1 Infectious and parasitic diseases A00 – B99

- Example: A01.0 Typhoid fever Infection due to Salmonella typhi
  - A01.00, Typhoid fever, unspecified
  - A01.01, Typhoid meningitis
  - A01.02, Typhoid fever with heart involvement
  - A01.03, Typhoid pneumonia
  - A01.04, Typhoid arthritis
  - A01.05, Typhoid osteomyelitis
  - A01.09, Typhoid fever with other complications

Documentation Example: Patient developed a rhythm disturbance due to Salmonella typhimurium
  - A01.03, Typhoid osteomyelitis
  - A01.09, Typhoid fever with other complications

Documentation Example: Patient developed a intestinal bleeding due to Typhoid
ICD 10 CM Documentation
Chapter Specifics

Chapter 1 Infectious and parasitic diseases A00 – B99

- Example: A01.0 Typhoid fever Infection due to Salmonella typhi
  - A01.00, Typhoid fever, unspecified
  - A01.01, Typhoid meningitis
  - A01.02, Typhoid fever with heart involvement
  - A01.09, Typhoid fever with other complications

Documentation Example: Patient developed a rhythm disturbance due to Salmonella typhimurium
  - A01.03, Typhoid osteomyelitis
  - A01.09, Typhoid fever with other complications

Documentation Example: Patient developed a gastrointestinal hemorrhage due to Typhoid
  - K92.2 Gastrointestinal hemorrhage, unspecified
ICD 10 CM Documentation
Chapter Specifics

Chapter 2 Neoplasm C00 – D49

• New guideline – use additional code to identify conditions such as: alcohol abuse/dependence, alcohol dependence in remission, tobacco dependence, and history of tobacco use

• There are Block of codes for in situ neoplasms and is located before the block for benign neoplasms

Document: Primary, Secondary, etc
Chapter 2 Neoplasm C00 – D49

New guideline – use additional code to identify conditions such as: alcohol abuse/dependence, alcohol dependence in remission, tobacco dependence, and history of tobacco use

There are blocks of codes for in situ neoplasms and is located before the block for benign neoplasms.

<table>
<thead>
<tr>
<th>Tissue Type</th>
<th>Malignant Primary</th>
<th>Malignant Secondary</th>
<th>Ca in situ</th>
<th>Benign</th>
<th>Uncertain Behavior</th>
<th>Unspecified Behavior</th>
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<tbody>
<tr>
<td>scaphoid</td>
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<td>C40.3-</td>
<td>C79.51</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>of ankle</td>
<td></td>
<td>C40.1-</td>
<td>C79.51</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>of hand</td>
<td></td>
<td>C40.0-</td>
<td>C79.51</td>
<td>-</td>
<td>D16.0-</td>
<td>-</td>
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<tr>
<td>scapula (any part)</td>
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<td>C79.51</td>
<td>-</td>
<td>D16.0-</td>
<td>-</td>
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<td>C79.51</td>
<td>-</td>
<td>D16.4-</td>
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<td>D48.0</td>
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<td>D48.0</td>
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<tr>
<td>toe (any)</td>
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<td>C40.3-</td>
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</table>
Chapter 2 Neoplasm C00 – D49

<table>
<thead>
<tr>
<th>Condition</th>
<th>Malignant Primary</th>
<th>Malignant Secondary</th>
<th>Ca in situ</th>
<th>Benign</th>
<th>Uncertain Behavior</th>
<th>Unspecified Behavior</th>
</tr>
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<td>scaphoid of ankle</td>
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<td>C79.51</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>scaphoid of hand</td>
<td>C40.1-</td>
<td>C79.51</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>scapula (any part)</td>
<td>C40.0-</td>
<td>C79.51</td>
<td>-</td>
<td>D16.0-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>sella turcica</td>
<td>C41.0</td>
<td>C79.51</td>
<td>-</td>
<td>D16.4-</td>
<td>D48.0</td>
<td>D49.2</td>
</tr>
<tr>
<td>shoulder</td>
<td>C40.0-</td>
<td>C79.51</td>
<td>-</td>
<td>D16.0-</td>
<td>D48.0</td>
<td>D49.2</td>
</tr>
<tr>
<td>skull</td>
<td>C41.0</td>
<td>C79.51</td>
<td>-</td>
<td>D16.4-</td>
<td>D48.0</td>
<td>D49.2</td>
</tr>
</tbody>
</table>

**C41.0** Malignant neoplasm of bones of skull and face

**C41.1** Malignant neoplasm of mandible

**C41.2** Malignant neoplasm of vertebral column

**C41.3** Malignant neoplasm of ribs, sternum and clavicle

**C41.4** Malignant neoplasm of pelvic bones, sacrum and coccyx

**C41.9** Malignant neoplasm of bone and articular cartilage, unspecified
ICD 10 CM Documentation

Chapter Specifics

Chapter 2 Neoplasm C00 – D49

- New guideline – use additional code to identify conditions such as: alcohol abuse/dependence, alcohol dependence in remission, tobacco dependence, and history of tobacco use
- There are Block of codes for in situ neoplasms and is located before the block for benign neoplasms

Document: any “due to” comorbidities

- Anemia
- Pain
ICD 10 CM Documentation
Chapter Specifics

Chapter 2 Neoplasm C00 – D49

- New guideline – use additional code to identify conditions such as: alcohol abuse/dependence, alcohol dependence in remission, tobacco dependence, and history of tobacco use
- There are Block of codes for in situ neoplasms and is located before the block for benign neoplasms

Document: any “due to” comorbidities

- Anemia
- Pain
  - G89.3 Neoplasm related pain (acute) (chronic)
    - Cancer associated pain
    - Pain due to malignancy (primary) (secondary)
    - Tumor associated pain
ICD 10 CM Documentation
Chapter Specifics

Chapter 3 Blood & Blood Forming Organs & Immunity
D50-D89

– Anemia - Physician documentation identifies
  • whether the anemia is associated with the neoplasm or an adverse effect of the treatment associated with the malignancy.
  • Whether it is due to underlying condition
  • Dietary deficiency
  • Blood loss
  • Identify, if applicable, toxic effect
    – D61.2 Aplastic Anemia due to other external agents – must document cause … Methanol? Benzene? Etc
## ICD 10 CM Documentation
### Chapter Specifics

<table>
<thead>
<tr>
<th>ICD 9 CM</th>
<th>ICD 10 CM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>281.2 Folate-deficiency anemia</strong></td>
<td>D52 Folate deficiency anemia</td>
</tr>
<tr>
<td></td>
<td>D52.0 Dietary folate deficiency anemia</td>
</tr>
<tr>
<td></td>
<td>D52.1 Drug-induced folate deficiency anemia</td>
</tr>
<tr>
<td></td>
<td>Code first (T36-T50) to identify drug</td>
</tr>
<tr>
<td></td>
<td>D52.8 Other folate deficiency anemias</td>
</tr>
<tr>
<td></td>
<td>D52.9 Folate deficiency anemia, unspecified</td>
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<td><strong>282.4 Thalassemias</strong></td>
<td>D56 Thalassemia</td>
</tr>
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<td>D56.0 Alpha thalassemia</td>
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<td>D56.1 Beta thalassemia</td>
</tr>
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<td></td>
<td>D56.2 Delta-beta thalassemia</td>
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<tr>
<td></td>
<td>D56.3 Thalassemia minor</td>
</tr>
<tr>
<td></td>
<td>D56.4 Hereditary persistence of fetal hemoglobin [HPFH]</td>
</tr>
<tr>
<td></td>
<td>D56.8 Other thalassemias</td>
</tr>
<tr>
<td></td>
<td>D56.9 Thalassemia, unspecified</td>
</tr>
</tbody>
</table>
ICD 10 CM Documentation
Chapter Specifics

Chapter 3 Blood & Blood Forming Organs & Immunity
D50-D89

Blood Loss Anemias

- Is it Acute or Chronic???
- Is it due to trauma, rupture of organ, post op
- Must have documentation of condition such as a sustained significant lowering of the hemoglobin level &/or hematocrit
- Chronic – must be documented
Blood Loss Anemias Posthemorrhagic

- Acute posthemorrhagic anemia D62
- Chronic posthemorrhagic anemia D50.0
  - Must be documented as due to surgery
  - Coder cannot assume - check with the doctor
    - If simply blood loss is mention
    - Postop blood count is low
    - Blood replacement given
Blood Loss Anemias

- **Acute posthemorrhagic anemia** (D62)
- **Chronic posthemorrhagic anemia** (D50.0)

  - Must be documented as due to surgery
  - Coder cannot assume
    - If simply blood loss is mentioned
    - Postop blood count is low
    - Blood replacement given

**ICD 10 CM Documentation**

- postprocedural - see also **Complications, surgical procedure**
  - cardiac arrest
    - following cardiac surgery (I97.120)
    - following other surgery (I97.121)
  - cardiac functional disturbance NEC
    - following cardiac surgery (I97.190)
    - following other surgery (I97.191)
  - cardiac insufficiency
    - following cardiac surgery (I97.110)
    - following other surgery (I97.111)
  - chorioretinal scars following retinal surgery (H59.81-)
    - following cataract surgery
      - cataract (lens) fragments (H59.02-)
      - cystoid macular edema (H59.03-)
      - specified NEC (H59.09-)
      - vitreous (touch) syndrome (H59.01-)
  - heart failure
    - following cardiac surgery (I97.130)
    - following other surgery (I97.131)
  - hemorrhage (hematoma) (of)
    - circulatory system organ or structure
      - following a cardiac bypass (I97.611)
      - following a cardiac catheterization (I97.610)
ICD 10 CM Documentation
Chapter Specifics

Chapter 4 Endocrine E00 – E89

• Diabetes
• ICD-9-CM – 59 Codes - single category (250)
• ICD-10-CM ) – More than 200 codes with five categories
  – expanded to reflect manifestations and/or
  complication

  E08 Diabetes mellitus due to underlying condition
  E09 Drug or chemical induced diabetes mellitus
  E10 Type 1 diabetes mellitus
  E11 Type 2 diabetes mellitus
  E13 Other specified diabetes mellitus
ICD 10 CM Documentation
Chapter Specifics
Chapter 4 Endocrine E00 – E89

4th or 5th characters identify the manifestation

- E08 Diabetes mellitus due to underlying condition
- E08.00 Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
- E09 Drug or chemical induced diabetes mellitus
- E10 Type 1 diabetes mellitus
- E11 Type 2 diabetes mellitus
- E13 Other specified diabetes mellitus
ICD 10 CM Documentation

Manifestations & Underlying Cause of Manifestations

- ICD-10-CM differentiates diabetic disease and disorders on the following characteristics: **Not by controlled or uncontrolled**
  - Diabetes mellitus due to other underlying condition
    - Cushing’s syndrome
    - Cystic fibrosis
    - Pancreatitis and other pancreatic disease
  - Drug or chemical induced diabetes mellitus
  - Diabetes mellitus Type 1 or Type 2
    - Type 1 (Juvenile)
    - Type 2 (Adult onset)
  - Other specified diabetes mellitus
    - Post procedural diabetes mellitus due to genetic defects of beta cell function
  - Secondary diabetes mellitus

Acuity Redefined:
- Hyperosmolarity (with and without coma)
- Ketoacidosis (with and without coma)
- Hypoglycemic (with and without coma)
- Hyperglycemia
ICD 10 CM Documentation

Manifestations & Underlying Cause of Manifestations

• Must document Relationship
• Must document Severity
• If type not specified will default to type 2
  – Assign as many codes from categories E08 – E13 as needed to identify all of the associated conditions
ICD 10 CM Documentation

Manifestations & Underlying Cause of Manifestations

Examples of documentation needed for Diabetes

- Diabetes mellitus Type 2, with foot ulcer complicated by episodes of hypoglycemia
- Chemical induced diabetes mellitus Type 2, with chronic kidney disease, CKD stage 4
- Status post pancreatectomy with secondary diabetes mellitus, ketoacidosis, and no coma
- Complete blindness in right eye due to Type 1 diabetes and severe nonproliferate retinopathy with macular edema
- Hyperglycemic Type 1 diabetes mellitus with peripheral vascular disease and gangrene of the right foot
- Diabetes without complications
ICD 10 CM Documentation
Chapter Specifics

Chapter 5 Mental and behavioral disorders F01 – F99

• Many codes have “code first” note so supporting documentation needed
  – “Code first the underlying physiological condition”
  – “Use additional code for blood alcohol level, if applicable (Y90.-)”

• Are there any associated physical issues?
• Document all conditions so all can be coded
• Is there any drugs or alcohol abuse &/or dependence involved?
Chapter 5 Mental and behavioral disorders F01 – F99

• Many codes have “code first” note so supporting documentation needed
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• Are there any associated physical issues?
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• Is there any drugs or alcohol abuse &/or dependence involved?

ICD 10 CM Documentation
Chapter Specifics

F10 Alcohol related disorders
  Use additional code for blood alcohol level, if applicable (Y90.-)

F10.1 Alcohol abuse
  Excludes1: alcohol dependence (F10.2-)
              alcohol use, unspecified (F10.9-)
  F10.10 Alcohol abuse, uncomplicated
  F10.12 Alcohol abuse with intoxication
    F10.120 Alcohol abuse with intoxication, uncomplicated
    F10.121 Alcohol abuse with intoxication delirium
    F10.129 Alcohol abuse with intoxication, unspecified
  F10.14 Alcohol abuse with alcohol-induced mood disorder
  F10.15 Alcohol abuse with alcohol-induced psychotic disorder
    F10.150 Alcohol abuse with alcohol-induced psychotic disorder with delusions
    F10.151 Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
    F10.159 Alcohol abuse with alcohol-induced psychotic disorder, unspecified
  F10.18 Alcohol abuse with other alcohol-induced disorders
    F10.180 Alcohol abuse with alcohol-induced anxiety disorder
    F10.181 Alcohol abuse with alcohol-induced sexual dysfunction
    F10.182 Alcohol abuse with alcohol-induced sleep disorder
    F10.188 Alcohol abuse with other alcohol-induced disorder
  F10.19 Alcohol abuse with unspecified alcohol-induced disorder

F10.2 Alcohol dependence
ICD 10 CM Documentation
Chapter Specifics
Chapter 5 Mental and behavioral disorders F01 – F99

More specific codes

• ICD 9 CM – 1 code
  – 315.32 Mixed receptive-expressive language disorder

• ICD 10 CM – 2 codes
  – H93.25 - Central auditory processing disorder
  – F80.2- Mixed receptive-expressive language disorder
ICD 10 CM Documentation
Chapter Specifics

Chapter 6 Diseases of Nervous System G00 – G99

• Same as ICD 9 CM, many codes need documentation of dominant or non-dominant

• G89 Pain not elsewhere classified
  – Acute? Chronic? Due to trauma? Post Surgical? Due to Neoplasm?

USE THE MORE SPECIFIC CODE…
G89 Pain, not elsewhere classified

**Code also** related psychological factors associated with pain (F45.42)

**Excludes1:**
- generalized pain NOS (R52)
- pain disorders exclusively related to psychological factors (F45.41)
- pain NOS (R52)

**Excludes2:**
- atypical face pain (G50.1)
- headache syndromes (G44.-)
- localized pain, unspecified type - code to pain by site, such as:
  - abdomen pain (R10.-)
  - back pain (M54.9)
  - breast pain (N64.4)
  - chest pain (R07.1-R07.9)
  - ear pain (H92.0-)
  - eye pain (H57.1)
  - headache (R51)
  - joint pain (M25.5-)
  - limb pain (M79.6-)
  - lumbar region pain (M54.5)
  - painful urination (R30.9)
  - pelvic and perineal pain (R10.2)
  - shoulder pain (M25.51-)
  - spine pain (M54.-)
  - throat pain (R07.0)
  - tongue pain (K14.6)
  - tooth pain (K08.8)
  - renal colic (N23)
Chapter 6 Diseases of Nervous System G00 – G99

R10 Abdominal and pelvic pain
  – R10.0 Acute abdomen
  – R10.1 Pain localized to upper abdomen
  – R10.2 Pain and perineal pain
  – R10.3 Pain localized to other parts of lower abdomen
  – R10.8 Other abdominal pain
    • R10.81 Abdominal tenderness
    • R10.82 Rebound abdominal tenderness
ICD 10 CM Documentation
Chapter Specifics

Chapter 6 Diseases of Nervous System

R10 Abdomen
- R10.0 Acute abdomen
- R10.1 Pain localized to upper abdomen
- R10.2 Pain and perineal pain
- R10.3 Pain localized to other parts of lower abdomen
- R10.8 Other abdominal pain
  - R10.81 Abdominal tenderness
    - R10.811 Right upper quadrant abdominal tenderness
    - R10.812 Left upper quadrant abdominal tenderness
    - R10.813 Right lower quadrant abdominal tenderness
    - R10.814 Left lower quadrant abdominal tenderness
    - R10.815 Periumbilical abdominal tenderness
    - R10.816 Epigastric abdominal tenderness
    - R10.817 Generalized abdominal tenderness
    - R10.819 Abdominal tenderness, unspecified site
  - R10.82 Rebound abdominal tenderness
Chapter 6 Diseases of Nervous System

G00 – G99

R10 Abdominal and pelvic pain
- R10.0 Acute abdomen
- R10.1 Pain localized to upper abdomen
- R10.2 Pain and perineal pain
- R10.3 Pain localized to other parts of lower abdomen
- R10.8 Other abdominal pain
  - R10.81 Abdominal tenderness
  - R10.82 Rebound abdominal tenderness

ICD 10 CM Documentation
Chapter Specifics

R07 Chest pain
- R07 Pain in throat and chest
  - R07.0 Pain in throat
  - R07.1 Chest pain on breathing
  - R07.2 Precordial pain
  - R07.8 Other chest pain
    - R07.81 Pleurodynia
      - R07.82 Intercostal pain
      - R07.89 Chest wall pain
ICD 10 CM Documentation

Chapter Specifics

Chapter 7 Eye & adnexa H00 – H59

- Completely new chapter – was included in Ch 6 in ICD 9 CM
- Updated terminology – “age-related cataracts” instead of “senile cataracts.”
- Many conditions of the eyes can be coded with conditions classified in other chapters
  - Infections/parasites
  - Diabetes
  - Injuries
- Laterality or both eyes
  - GREATER SPECIFICITY & LATERALITY
# ICD 10 CM Documentation

## Chapter Specifics

<table>
<thead>
<tr>
<th>ICD 9 CM – 4 Categories</th>
<th>ICD 10 CM 6 Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>372.0</strong> Acute conjunctivitis</td>
<td><strong>H10.0</strong> Mucopurulent conjunctivitis, Acute follicular; Other mucopurulent</td>
</tr>
<tr>
<td>Acute, unspecified; Serous, except viral; Acute follicular; Other mucopurulent; Pseudomembranous; Acute atopic; Acute chemical</td>
<td><strong>H10.1</strong> Acute atopic conjunctivitis; Other acute; Acute toxic; Pseudomembranous: Serous conjunctivitis, except viral</td>
</tr>
<tr>
<td><strong>372.1</strong> Chronic conjunctivitis</td>
<td><strong>H10.3</strong> Unspecified acute conjunctivitis</td>
</tr>
<tr>
<td>Chronic, unspecified; Simple chronic; Chronic follicular; Vernal conjunctivitis; Parasitic conjunctivitis</td>
<td><strong>H10.4</strong> Chronic; Unspecified chronic; Chronic giant papillary; Simple chronic; Chronic follicular; Vernal conjunctivitis; Other chronic allergic</td>
</tr>
<tr>
<td><strong>372.2</strong> Blepharoconjunctivitis</td>
<td><strong>H10.5</strong> Blepharoconjunctivitis; Unspecified; Ligneous; Angular; Contact</td>
</tr>
<tr>
<td>Unspecified; Angular; Contact</td>
<td><strong>H10.8</strong> Other conjunctivitis; Pingueculitis; Other; Unspecified conjunctivitis</td>
</tr>
<tr>
<td><strong>372.3</strong> Other and unspecified conjunctivitis; Unspecified; Rosacea; in mucocutaneous disease; Pingueculitis</td>
<td></td>
</tr>
</tbody>
</table>

**ICD 10 CM**

- **H00** – **H59**
- **ICD**
  - **ICD 9 CM** – 4 Categories
  - **ICD 10 CM** – 6 Categories
ICD 10 CM Documentation

Chapter Specifics

- **H10.0** Mucopurulent conjunctivitis
  - **H10.01** Acute follicular conjunctivitis
    - **H10.011** ...... right eye
    - **H10.012** ...... left eye
    - **H10.013** ...... bilateral
    - **H10.019** ...... unspecified eye

- **H10.3** Unspecified acute conjunctivitis

- **H10.4** Chronic; Unspecified chronic; Chronic giant papillary; Simple chronic; Chronic follicular; Vernal conjunctivitis; Other chronic allergic

- **H10.5** Blepharoconjunctivitis; Unspecified; Ligneous; Angular; Contact blepharoconjunctivitis

- **H10.8** Other conjunctivitis; Pingueculitis; Other; Unspecified conjunctivitis

- **372.3** Other and unspecified conjunctivitis; Unspecified; Rosacea; in mucocutaneous disease; Pingueculitis
ICD 10 CM Documentation
Chapter Specifics

E11.3 Type 2 diabetes mellitus with ophthalmic complications
  - E11.31 Type 2 diabetes mellitus with unspecified diabetic retinopathy
    - E11.311 ...... with macular edema
    - E11.319 ...... without macular edema
  - E11.32 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy
    - E11.321 ...... with macular edema
    - E11.329 ...... without macular edema
  - E11.33 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy
    - E11.331 ...... with macular edema
    - E11.339 ...... without macular edema
  - E11.34 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy
    - E11.341 ...... with macular edema
    - E11.349 ...... without macular edema
  - E11.35 Type 2 diabetes mellitus with proliferative diabetic retinopathy
    - E11.351 ...... with macular edema
    - E11.359 ...... without macular edema
  - E11.36 Type 2 diabetes mellitus with diabetic cataract
  - E11.39 Type 2 diabetes mellitus with other diabetic ophthalmic complication
ICD 10 CM Documentation
Chapter Specifics

Chapter 8 Diseases of the ear and mastoid process  H60 – H95

• Completely new chapter
• Tobacco Coding Required
  – Also: use an additional code, where applicable to identify:
    – Z77.22 exposure to environmental tobacco smoke
    – P96.81, exposure to tobacco smoke in the perinatal period
    – Z87.891, history of tobacco use
    – Z57.31 occupational exposure to environmental tobacco smoke
    – F17.-, tobacco dependence
    – Z72.0 tobacco use
ICD 10 CM Documentation
Chapter Specifics

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    - Z87.891, history of tobacco use
    - Z57.31 occupational exposure to environmental tobacco smoke
    - F17.-, tobacco dependence
    - Z72.0 tobacco use
AMI Documentation:
- Acute MI reduced from 8 to 4 weeks (28 days) or less from onset
- New categories for subsequent AMI and for complications within 28 days of AMI.
- Stemi or NonStemi
- Exact location
- Laterality

“I21.02 nfarction [STEMI] involving left anterior descending coronary artery”
ICD 10 CM Documentation
Chapter Specifics

Chapter 9 Diseases Circulatory System I00 – I99

Terminology Change

- ICD9CM Intermediary coronary syndrome
- ICD10CM Unstable angine
- ICD9CM acute myocardial infarction
- ICD10CM STEMI and NSTEMI myocardial infarction

Hypertension

- Hypertension no longer classified by type (i.e., benign, malignant, unspecified)
- As with ICD 9 CM - if heart condition due to hypertension – causal relationship MUST be documented.
ICD 10 CM Documentation

- **Congestive Heart Failure – Same as ICD 9 CM**
  - “Use additional code” for stage of CKD & type of heart failure
    - I50.30 Unspecified diastolic (congestive) heart failure
    - I50.31 Acute diastolic (congestive) heart failure
    - I50.32 Chronic diastolic (congestive) heart failure
    - I50.33 Acute on chronic diastolic (congestive) heart failure
    - I50.40 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
    - I50.41 Acute combined systolic (congestive) and diastolic (congestive) heart failure
    - I50.42 Chronic combined systolic (congestive) and diastolic (congestive) heart failure
    - I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
    - I50.9 Heart failure, unspecified
    - R57.0 Cardiogenic shock
    - R57.9 Shock, unspecified

I509 Unspecified CHF not a CC and Not a MCC
ICD 10 CM Documentation

What to document with CHF

- Systolic/diastolic?
- Acute on chronic exacerbation?
- Emphysema? Which lobe? With COPD?
- Morbid obesity? What is the BMI?
- Chronic respiratory failure? Possible COPD/Emphysema
- CKD? Stage of CKD?
- Was there any Acute Kidney Failure?
- Hypertensive renal failure/ with CHF/ with CKD stage? - (Triggering a code combination impacts the MDC assignment and DRG)
- Hypertensive renal failure/ with CHF with acute exacerbation?
ICD 10 CM Documentation
Chapter Specifics

- Documentation Details are Paramount in Chapter 9 codes

Example: Subarachnoid Hemorrhage - Patient is discharged with principal diagnosis of nontraumatic subarachnoid hemorrhage, commonly known as a stroke

In ICD-9-CM there is one code:
- 430 Subarachnoid hemorrhage

In ICD-10-CM - twenty possible codes requiring detail of which artery the hemorrhage came from for accurate code assignment.

- right and left carotid siphon and bifurcation;
- right and left middle cerebral;
- right and left anterior communicating;
- right and left posterior communicating;
- basilar; right and left vertebral;
- and other or unspecified intracranial arteries.
ICD 10 CM Documentation
Chapter Specifics

Chapter 10 Diseases of Respiratory System J00 – J99

- Tobacco involvement?
- Any Infectious agents? Lung Abscess?
- Any Manifestation & Underlying Disease
  - Pneumonia
  - document infective agent when established and link it to the pneumonia as the cause.
  - often have an additional complicating diagnosis of sepsis or respiratory failure that will require specific documentation.
  - complications such as with sepsis, shock, respiratory failure, or as a result of a procedure.
ICD 10 CM Documentation

• Pneumonia - Bacterial

All of these codes are MCCs when listed as secondary diagnoses

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J13</td>
<td>Pneumonia due to Streptococcus pneumoniae</td>
</tr>
<tr>
<td>J14</td>
<td>Pneumonia due to Hemophilus influenzae</td>
</tr>
<tr>
<td>J153</td>
<td>Pneumonia due to streptococcus, group B</td>
</tr>
<tr>
<td>J154</td>
<td>Pneumonia due to other streptococci</td>
</tr>
<tr>
<td>J157</td>
<td>Pneumonia due to Mycoplasma pneumoniae</td>
</tr>
<tr>
<td>J159</td>
<td>Unspecified bacterial pneumonia</td>
</tr>
<tr>
<td>J160</td>
<td>Chlamydial pneumonia</td>
</tr>
<tr>
<td>J168</td>
<td>Pneumonia due to other specified infectious organisms</td>
</tr>
<tr>
<td>J180</td>
<td>Bronchopneumonia, unspecified organism</td>
</tr>
<tr>
<td>J181</td>
<td>Lobar pneumonia, unspecified organism</td>
</tr>
<tr>
<td>J188</td>
<td>Other pneumonia, unspecified organism</td>
</tr>
<tr>
<td>J189</td>
<td>Pneumonia, unspecified organism</td>
</tr>
</tbody>
</table>

Provider documentation

• highest level of certainty known
• highest specificity (may sometimes have to use possible/probable
What to document with Pneumonia

- Was the Patient intubated? For what diagnosis?
- Acute hypoxia?
- Change of mental status? Due to anoxic encephalopathy? (patient hypoxic enough to require intubation)?
- Was patient on ventilator? How long?
- Acute hypoxic respiratory failure?
- Was this respiratory failure POA?
- Was the respiratory failure the reason for admission?
- Co-equal diagnosis of pneumonia, and respiratory failure?
- Sputum cultures are positive for?
ICD 10 CM Documentation

Asthma - Documentation required - “severity” of acute aspect of the chronic condition such as “acute”, “Exacerbation” & “Status Asthmaticus”

Intermittent asthma (J45.2-)
- Symptoms (difficulty breathing, wheezing, chest tightness, and coughing):
  - Occur on fewer than 2 days a week.
  - Do not interfere with normal activities.
  - Nighttime symptoms occur on fewer than 2 days a month.
- Lung function tests (spirometry and peak expiratory flow [PEF])

Mild persistent asthma (J45.3-)
- Symptoms occur on more than 2 days a week but do not occur every day.
- Attacks interfere with daily activities.
- Nighttime symptoms occur 3/4 times a mo.
Lung function tests are normal when the person is not having an asthma attack.

Moderate persistent asthma (J45 4-)
- Symptoms occur daily.
- Inhaled short-acting asthma medication is used every day.
- Symptoms interfere with daily activities.
- Nighttime symptoms occur more than 1 time a week, but do not happen every day.
- Lung function tests are abnormal

Severe persistent asthma (J45.5-)
- Symptoms occur throughout each day.
- Severely limit daily physical activities.
- Nighttime symptoms occur often, sometimes every night.
- Lung function tests are abnormal.
ICD 10 CM Documentation
Chapter Specifics

Chapter 11 Diseases of Digestive System K00 – K95

• Oral cavity, salivary glands, ulcers, hernias
• Document any obstruction = incarcerated, irreducible or strangulated
• Document whether with or without hemorrhage
• ICD-10-CM diseases of the liver have their own subchapter or block while these conditions were grouped with other diseases of the digestive system in ICD-9-CM.
ICD 10 CM Documentation
Chapter Specifics

Chapter 11 Diseases of Digestive System K00 – K95

• Dental Coding:
• Very Similar codes as ICD 9 CM
  – But more detail on loss of teeth
<table>
<thead>
<tr>
<th>K08.4</th>
<th>Partial loss of teeth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquired loss of teeth, partial</td>
<td></td>
</tr>
</tbody>
</table>

**Excludes1**: complete loss of teeth (K08.1-)

- congenital absence of teeth (K00.0)

**Excludes2**: exfoliation of teeth due to systemic causes (K08.0)

<table>
<thead>
<tr>
<th>K08.40</th>
<th>Partial loss of teeth, unspecified cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>K08.401</td>
<td>Partial loss of teeth, unspecified cause, class I</td>
</tr>
<tr>
<td>K08.402</td>
<td>Partial loss of teeth, unspecified cause, class II</td>
</tr>
<tr>
<td>K08.403</td>
<td>Partial loss of teeth, unspecified cause, class III</td>
</tr>
<tr>
<td>K08.404</td>
<td>Partial loss of teeth, unspecified cause, class IV</td>
</tr>
<tr>
<td>K08.409</td>
<td>Partial loss of teeth, unspecified cause, unspecified class</td>
</tr>
</tbody>
</table>

**Tooth extraction status NOS**

<table>
<thead>
<tr>
<th>K08.41</th>
<th>Partial loss of teeth due to trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>K08.411</td>
<td>Partial loss of teeth due to trauma, class I</td>
</tr>
<tr>
<td>K08.412</td>
<td>Partial loss of teeth due to trauma, class II</td>
</tr>
<tr>
<td>K08.413</td>
<td>Partial loss of teeth due to trauma, class III</td>
</tr>
<tr>
<td>K08.414</td>
<td>Partial loss of teeth due to trauma, class IV</td>
</tr>
<tr>
<td>K08.419</td>
<td>Partial loss of teeth due to trauma, unspecified class</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>K08.42</th>
<th>Partial loss of teeth due to periodontal diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>K08.421</td>
<td>Partial loss of teeth due to periodontal diseases, class I</td>
</tr>
<tr>
<td>K08.422</td>
<td>Partial loss of teeth due to periodontal diseases, class II</td>
</tr>
<tr>
<td>K08.423</td>
<td>Partial loss of teeth due to periodontal diseases, class III</td>
</tr>
<tr>
<td>K08.424</td>
<td>Partial loss of teeth due to periodontal diseases, class IV</td>
</tr>
<tr>
<td>K08.429</td>
<td>Partial loss of teeth due to periodontal diseases, unspecified class</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>K08.43</th>
<th>Partial loss of teeth due to caries</th>
</tr>
</thead>
<tbody>
<tr>
<td>K08.431</td>
<td>Partial loss of teeth due to caries, class I</td>
</tr>
<tr>
<td>K08.432</td>
<td>Partial loss of teeth due to caries, class II</td>
</tr>
<tr>
<td>K08.433</td>
<td>Partial loss of teeth due to caries, class III</td>
</tr>
<tr>
<td>K08.434</td>
<td>Partial loss of teeth due to caries, class IV</td>
</tr>
</tbody>
</table>
ICD 10 CM Documentation
Chapter Specifics

Chapter 11 Diseases of Digestive System K00 – K95

• Dental Coding in the Index

Dental - see also condition

examination  Z01.20
with abnormal findings  Z01.21
restoration
aesthetically inadequate or displeasing  K08.56
defective  K08.50
specified NEC  K08.59
failure of marginal integrity  K08.51
failure of periodontal anatomical integrity  K08.54
Dentia praecoxx  K00.6
Chapter 11 Diseases of Digestive System

- Dental Coding in the Index

Dental - see also condition
  examination Z01.20
  with abnormal findings Z01.21
  restoration
  aesthetically inadequate or displeasing defective K08.50
  specified NEC K08.59
  failure of marginal integrity K08.51
  failure of periodontal anatomical integrity

Dentia praecox K00.6
ICD 10 CM Documentation
Chapter Specifics

Chapter 12 Diseases Skin & Subcu tissue L00 – L99

• Greater specificity has been added to many of the codes.
• Dermatitis: diaper, allergic contact, allergic irritant and what due to (external or internal), exfoliative, infective, nummular etc
  – Is it Irritant?
  – Underlying drugs?
  – Additional complications
ICD 10 CM Documentation
Chapter Specifics

Chapter 12 Diseases Skin & Subcu tissue L00 – L99

• Two categories for allergic (L23) and irritant (L24) contact dermatitis, Instruction:

• Example:
  • L23 Allergic contact dermatitis
  • Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)
  • L24 Irritant contact dermatitis
  • Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)

• Dermatitis and eczema are used synonymously and interchangeably
ICD 10 CM Documentation
Chapter Specifics

Chapter 12 Diseases Skin & Subcu tissue L00 – L99

- Document site and severity of the decubitus ulcer
- **Pressure Ulcers** - ICD-10-CM provides the site (including laterality) and the stage all in one code.
  - Category L89, Pressure ulcer, are combination codes that identify the site AND the stage of the ulcer.
  - Pressure ulcer stages based on severity, which is designated by stages 1-4, unspecified stage and unstageable
  - Assign as many codes from category L89 as needed to identify all the pressure ulcers
ICD 10 CM Documentation
Chapter Specifics

Chapter 12 Diseases Skin & Subcu tissue L00 – L99

Documentation for Ulcers

- Is it Decubitus?
- Is it Stasis?
- What is the site? (including laterality)
  - Code each site separately
- Is there an underlying condition?

USE MULTIPLE CODES IF NECESSARY
Chapter 12 Diseases Skin & Subcu tissue L00 – L99

**ICD 10 CM Documentation**

Chapter Specifics

**Pressure ulcer of right ankle**

- **L89.51** Pressure ulcer of right ankle
  - **L89.510** Pressure ulcer of right ankle, unstageable
  - **L89.511** Pressure ulcer of right ankle, stage 1
    - Healing pressure ulcer of right ankle, stage 1
    - Healing pre-ulcer skin changes limited to persistent focal edema, right ankle
  - **L89.512** Pressure ulcer of right ankle, stage 2
    - Healing pressure ulcer of right ankle, stage 2
    - Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis, right ankle
  - **L89.513** Pressure ulcer of right ankle, stage 3
    - Healing pressure ulcer of right ankle, stage 3
    - Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue, right ankle
  - **L89.514** Pressure ulcer of right ankle, stage 4
    - Healing pressure ulcer of right ankle, stage 4
    - Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone, right ankle
  - **L89.519** Pressure ulcer of right ankle, unspecified stage
    - Healing pressure ulcer of right ankle NOS
    - Healing pressure ulcer of right ankle, unspecified stage
ICD 10 CM Documentation
Chapter Specifics
Chapter 12 Diseases Skin & Subcu. tissue L00 – L99
Documentation for Lesions, Abscess, Cysts Ulcers & Wounds
• Is it traumatic?
• Is it chronic?
• Is it acute on chronic?
• Is there tendon &/or nerve involvement?
• Additional codes?
  – Is it an open wound
  – Is it a wound or a superficial injury
ICD 10 CM Documentation
Chapter Specifics

Chapter 13 Musculoskeletal & Connective tissue M00 – M99

- Most codes have site and laterality designations
- Site presents either the •bone •joint •or other muscle involved
- All fracture codes in Chapter 19 Injury, Poisoning & Certain Other Consequences of External Causes

- Chapter 13 Sections are as follows:
ICD 10 CM Documentation

Chapter Specifics

Chapter 13: Musculoskeletal & Connective tissue M00 – M99

- Most codes have site and laterality designations
- Site presents either the bone, joint, or other muscle involved
- All fracture codes in Chapter 19: Injury, Poisoning & Certain Other Consequences of External Causes

Intestinal infectious diseases (A00-A09)
Tuberculosis (A15-A19)
Certain zoonotic bacterial diseases (A20-A28)
Other bacterial diseases (A30-A49)
Infections with a predominantly sexual mode of transmission (A50-A64)
Other spirochetal diseases (A65-A69)
Other diseases caused by chlamydiae (A70-A74)
Rickettsioses (A75-A79)
Viral and prion infections of the central nervous system (A80-A89)
Arthropod-borne viral fevers and viral hemorrhagic fevers (A90-A99)
Viral infections characterized by skin and mucous membrane lesions (B00-B09)
Other human herpesviruses (B10)
Viral hepatitis (B15-B19)
Human immunodeficiency virus [HIV] disease (B20)
Other viral diseases (B25-B34)
Mycoses (B35-B49)
Protozoal diseases (B50-B64)
Helminthiases (B65-B83)
Pediculosis, acarasis and other infestations (B85-B89)
Sequelae of infectious and parasitic diseases (B90-B94)
Bacterial and viral infectious agents (B95-B97)
Other infectious diseases (B99)
ICD 10 CM Documentation
Chapter Specifics

Chapter 13 Musculoskeletal & Connective tissue M00 – M99

• Internal Derangement of the knee – category M23
  – M23.0_ Cystic meniscus
  – M23.2_ Derangement of meniscus due to old tear/injury
  – M23.3_ Other meniscus derangements
  – M23.4_ Loose body in knee
  – M23.5_ Chronic instability of knee

• According to:
  – Cystic or other
  – Site
  – Age

• BE CAREFUL - These codes are for Older tears and Cystic lesions
• For Current tears - Injury
ICD 10 CM Documentation Chapter Specifics

Chapter 13 Musculoskeletal & Connective tissue M00 – M99

• Internal Derangement of the knee – category M23
  – M23.0_ Cystic meniscus
  – M23.2_ Derangement of meniscus due to old tear/injury
  – M23.3_ Other meniscus derangements
  – M23.4_ Loose body in knee
  – M23.5_Chronic instability of knee

Document

• What is anatomical site - Which areas within the site are involved

• Is it due to a current injury?
  • If current – an External Cause Code

BE CAREFUL - These codes are for Older tears and Cystic lesions

For Current tears - Injury

• According to:
  – Cystic or other
  – Site

ICD 10 CM Documentation
Chapter Specifics
Example: Internal derangement of right knee, due to old medial meniscal tear

M23.203 Derangement, knee, meniscus, due to old tear or injury, medial (right)
Example: Internal derangement of right knee, due to old medial meniscal tear

M23.203 Derangement, knee, meniscus, due to old tear or injury, medial (right)

- identify site (knee)
- underlying cause (old tear or injury) of specific site medial meniscus.
- sixth character to specify the right
ICD 10 CM Documentation
Chapter Specifics

Chapter 14 Diseases Genitourinary N00 – N99

• To code to the highest level of specificity for post-traumatic urethral stricture, need to identify the patient’s gender.

• As ICD 9 CM, need documentation of stages of CKD

• Document any causal bacteria
Why so many codes?

**Use additional code (B95-B97) to ID infectious agent**

**These are more specific code choice selection available in ICD-10-CM. These include:**
Why so many codes?

UTI - ICD-9-CM 599.0 Urinary tract infection, site not specified

ICD-10-CM N39.0 Urinary tract infection, site not specified

**Use additional code (B95-B97) to ID infectious agent**

These are more specific code choice selection available in ICD-10-CM. These include:

- N30.00 Acute cystitis without hematuria
- N30.01 Acute cystitis with hematuria
- N30.10 Interstitial cystitis (chronic) without hematuria
- N30.11 Interstitial cystitis (chronic) with hematuria
- N30.20 Other chronic cystitis without hematuria
- N30.21 Other chronic cystitis with hematuria
- N30.30 Trigonitis without hematuria
- N30.31 Trigonitis with hematuria
- N30.40 Irradiation cystitis without hematuria
- N30.41 Irradiation cystitis with hematuria
- N30.80 Other cystitis without hematuria
- N30.81 Other cystitis with hematuria
- N30.90 Cystitis, unspecified without hematuria
- N30.91 Cystitis, unspecified with hematuria
- N15.9 Renal tubulo-interstitial disease, unspecified
ICD 10 CM Documentation
Chapter Specifics

Chapter 15 Pregnancy, Childbirth, and the Puerperium – O00 – O9A

• Episode of care has been removed
• ICD-10-CM basis pregnancy on trimester in which the condition trimester in which the condition occurred
  – High Risk or Low Risk
    • Routine OPD with no complications , a code from category Z34, Encounter for supervision of normal pregnancy,
    • High-risk OPD with no complications code from category O09, Supervision of high-risk pregnancy-first-listed diagnosis.
      – Secondary chapter 15 codes may be used in conjunction with these codes if appropriate.
ICD 10 CM Documentation
Chapter Specifics

Chapter 15 Pregnancy, Childbirth, and the Puerperium – O00 – O9A

• Document if pre-existing conditions (HIV, Diabetes, Hypertension)
ICD 10 CM Documentation

Additional Information
- A seventh character to identify the fetus to which certain complication codes apply
  - Example: O32 Maternal care for malpresentation of fetus
    - 0 not applicable or unspecified
    - 1 fetus 1
    - 2 fetus 2
    - 3 fetus 3
    - 4 fetus 4
    - 5 fetus 5
    - 9 other fetus
- Also more specificity in Multiple Gestations – Look at 030
ICD 10 CM Documentation

Additional Information

- O30  Multiple gestation
  
  Code also any complications specific to multiple gestation

  O30.0 Twin pregnancy

  O30.00 Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs

  O30.001 Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester

  O30.002 Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester

  O30.003 Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester

- 5 fetus 5

- 9 other fetus

- Also more specificity in Multiple Gestations – Look at 030
ICD 10 CM Documentation
Chapter Specifics

Chapter 16 Certain Conditions Perinatal Period P00

<table>
<thead>
<tr>
<th>Light-for-dates(infant)</th>
<th>Small-for-dates(infant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>P05.00 with weight of</td>
<td>P05.10 with weight of</td>
</tr>
<tr>
<td>499 grams or less</td>
<td>499 grams or less</td>
</tr>
<tr>
<td>500-749 grams</td>
<td>500-749 grams</td>
</tr>
<tr>
<td>750-999 grams</td>
<td>750-999 grams</td>
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<td>1000-1249 grams</td>
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<td>1750-1999 grams</td>
<td>1750-1999 grams</td>
</tr>
<tr>
<td>2000-2499 grams</td>
<td>2000-2499 grams</td>
</tr>
</tbody>
</table>
ICD 10 CM Documentation
Chapter Specifics

Chapter 16 Certain Conditions Perinatal Period P00 – P96

• If a newborn has a condition that may be either due to the birth process or community acquired and the documentation does not indicate which it is, the default is due to the birth process and the code from Chapter 16 should be used.

• If the condition is community-acquired, a code from Chapter 16 should not be assigned.
ICD 10 CM Documentation
Chapter Specifics

Chapter 17 Congenital Malformation, deformities & chromosomal abnormalities Q00 – Q99

- Codes from Chapter 17 may be used throughout the life of the patient.
- If a congenital malformation or deformity has been corrected, a personal history code should be used to identify the history of the malformation or deformity.
ICD 10 CM Documentation

Chapter Specifics

Chapter 17 Congenital Malformation, deformities & chromosomal abnormalities Q00 – Q99

- Classification changes that provide greater specificity
- Example:
  - Q35.1 Cleft hard palate
  - Q35.3 Cleft soft palate
  - Q35.5 Cleft hard palate with cleft soft palate
  - Q35.7 Cleft uvula
  - Q35.9 Cleft palate, unspecified
Chapter 18 Signs Symptoms Lab Findings R00 – P99

• Same guidelines as ICD 9 CM
• Scrutinized the frequency with which unspecified and “not otherwise specified” (NOS) codes currently are assigned appropriately.
• Chapter 16 “Symptoms, Signs and Ill-Defined Conditions” (780 – 799),
• Chapter 18 (renamed)“Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified” (R00-R99).
Chapter 18 Signs Symptoms Lab Findings R00 – P99

Codes found within this range include:

- no more specific diagnosis can be made even after all the facts bearing on the case have been investigated
- signs or symptoms existing at time of initial encounter that proved to be transient & causes could not be determined
- provisional diagnosis in a patient who failed to return for further investigation or care;
- cases referred elsewhere for investigation or treatment before the diagnosis was made;
- cases in which a more precise diagnosis was not available for any other reason
ICD 10 CM Documentation
Chapter Specifics
Chapter 19 Injury Poisoning & Consequences External Causes S00 – T88

• Most codes have extensions A, D or S with the exception of fractures
  – Extension "A", initial encounter Extension "D", subsequent encounter Extension "S", sequela

• “Sequela” - Document the injury code that precipitated the sequela
ICD 10 CM Documentation
Chapter Specifics
Chapter 19 Injury Poisoning & Consequences External Causes S00 – T88

- ICD-9-CM Type of injury - first axis of classification for the injuries
- ICD 10 CM categories S00-S99 of Chapter 19, are arranged by body region beginning with the head and concluding with the ankle and foot.
  - This results in the grouping of injury types together under the site where it occurred.
  - In addition, generally the listings of conditions that follow the site are as follows:
ICD 10 CM Documentation
Chapter Specifics
Chapter 19 Injury Poisoning & Consequences External Causes S00 – T88

By Site
- S00-S09 Injuries to the head
- S10-S19 Injuries to the neck
- S20-S29 Injuries to the thorax
- S30-S39 Injuries to the abdomen, Lower back, lumbar spine, pelvis & external genitals
- S40-S49 Injuries to shoulder & upper arm
- S50-S59 Injuries to the elbow & forearm
- S60-S69 Injuries to the wrist and hand
- S70-S79 Injuries to the hip & thigh
- S80-S89 Injuries to the knee and lower leg
- S90-S99 Injuries to the ankle & foot

- Superficial injury
- Open wound
- Fracture
- Dislocation and sprain
- Injury of nerves
- Injury of blood vessels
- Injury of muscle & tendon
- Crushing injury
- Traumatic amputation
- Other & unspecified injuries
ICD 10 CM

7th Character Extension

S00  Superficial injury of head

Excludes1:  diffuse cerebral contusion (S06.2-)
           focal cerebral contusion (S06.3-)
           injury of eye and orbit (S05.-)
           open wound of head (S01.-)

The appropriate 7th character is to be added to each code from category S00
A - initial encounter
D - subsequent encounter
S - sequela

S00.0  Superficial injury of scalp

S00.00  Unspecified superficial injury of scalp
S00.01  Abrasion of scalp
S00.02  Blister (nonthermal) of scalp
S00.03  Contusion of scalp
        Bruise of scalp
ICD 10 CM Documentation
Chapter Specifics
Chapter 19 Injury Poisoning & Consequences External Causes S00 – T88

- Assign separate codes for each injury unless a combination code
- Code T07, Unspecified multiple injuries NOT for inpatient setting (if Possible)
- Superficial injuries of same site not coded additionally
- A fracture - open or closed? Defaults to closed.
- A fracture - displaced or not displaced? Defaults to displaced
ICD 10 CM Documentation
Chapter Specifics
Chapter 19 Injury Poisoning & Consequences External Causes S00 – T88

Example: Skull Fractures ?
ICD 10 CM Documentation
Chapter Specifics
Chapter 19 Injury Poisoning & Consequences External Causes S00 – T88

Skull Fractures

- Site
  - Vault, base, mandible, orbital etc.
- Code First
  - Associated cranial injuries - S06-
    - With or without Loss of Consciousness and how long?
- Code Additionally
  - Open head wound S01-
- 7th Character A, D, S
Details of Laterality

- Musculoskeletal/Orthopedic
  - Laterality, specific bone and specific bone portion

**S82.12 Fracture of lateral condyle of tibia**
- S82.121 Displaced fracture of lateral condyle of right tibia
- S82.122 Displaced fracture of lateral condyle of left tibia
- S82.123 Displaced fracture of lateral condyle of unspecified tibia
- S82.124 Nondisplaced fracture of lateral condyle of right tibia
- S82.125 Nondisplaced fracture of lateral condyle of left tibia
- S82.126 Nondisplaced fracture of lateral condyle of unspecified tibia

**S82.13 Fracture of medial condyle of tibia**
- S82.131 Displaced fracture of medial condyle of right tibia
- S82.132 Displaced fracture of medial condyle of left tibia
- S82.133 Displaced fracture of medial condyle of unspecified tibia
- S82.134 Nondisplaced fracture of medial condyle of right tibia
- S82.135 Nondisplaced fracture of medial condyle of left tibia
- S82.136 Nondisplaced fracture of medial condyle of unspecified tibia
ICD 10 CM Documentation
Chapter Specifics
Chapter 19 Injury Poisoning & Consequences External Causes S00 – T88

- Assign separate codes for each injury unless a combination code
- Code T07, Unspecified multiple injuries NOT for inpatient setting (if Possible)
- Superficial injuries of same site not coded additionally
- A fracture - open or closed? Defaults to closed.
- A fracture - displaced or not displaced? Defaults to displaced
Example: Current Knee Injury

The Patient presents with a complex derangement of left internal meniscus with a bucket handle tear of lateral meniscus.

S83.232A Complex tear of medial meniscus, current injury, left knee, initial encounter
ICD 10 CM Documentation
Chapter 19

Fractures

- Greater specificity
  - Type of fracture
  - Specific anatomical site
  - Displaced vs nondisplaced
  - Laterality
  - Routine vs delayed healing
  - Nonunion
  - Malunion
  - Type of encounter
ICD 10 CM Documentation
Chapter 19

Example: Greenstick fracture of shaft of humerus, right arm
- **ICD-10-CM** S42.311K

*S42.3 Fracture of shaft of humerus*
- Fracture of humerus NOS
- Fracture of upper arm NOS

*Excludes 2: physisal fractures of upper end of humerus (S49.0-)*
- physisal fractures of lower end of humerus (S49.1-)

*S42.30 Unspecified fracture of shaft of humerus*
- S42.301 Unspecified fracture of shaft of humerus, right arm
- S42.302 Unspecified fracture of shaft of humerus, left arm
- S42.309 Unspecified fracture of shaft of humerus, unspecified arm

*S42.31 Greenstick fracture of shaft of humerus*

The appropriate 7th character is to be added to all codes in subcategory S42.31
- A - initial encounter for closed fracture
- D - subsequent encounter for fracture with routine healing
- G - subsequent encounter for fracture with delayed healing
- K - subsequent encounter for fracture with nonunion
- P - subsequent encounter for fracture with malunion
- S - sequela

*S42.311 Greenstick fracture of shaft of humerus, right arm
S42.312 Greenstick fracture of shaft of humerus, left arm
S42.319 Greenstick fracture of shaft of humerus, unspecified arm

**ICD-9-CM 733.82**
ICD 10 CM Documentation

Chapter 19

S52 Fracture of forearm

Note: A fracture not indicated as displaced or nondisplaced should be coded to displaced. A fracture not indicated as open or closed should be coded to closed. The open fracture designations are based on the Gustilo open fracture classification.

Excludes1: traumatic amputation of forearm (S58.-)
Excludes2: fracture at wrist and hand level (S62.-)

The appropriate 7th character is to be added to all codes from category S52:
- A - initial encounter for closed fracture
- B - initial encounter for open fracture type I or II
- initial encounter for open fracture NOS
  - C - initial encounter for open fracture type IIIA, IIIB, or IIIC
  - D - subsequent encounter for closed fracture with routine healing
  - E - subsequent encounter for open fracture type I or II with routine healing
  - F - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
  - G - subsequent encounter for closed fracture with delayed healing
  - H - subsequent encounter for open fracture type I or II with delayed healing
  - J - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
  - K - subsequent encounter for closed fracture with nonunion
  - M - subsequent encounter for open fracture type I or II with nonunion
  - N - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
  - P - subsequent encounter for closed fracture with malunion
  - Q - subsequent encounter for open fracture type I or II with malunion
  - R - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion
  - S - sequela

S52.0 Fracture of upper end of ulna
Fracture of proximal end of ulna

Excludes2: fracture of elbow NOS (S42.40-)
fractures of shaft of ulna (S52.2-)

S52.00 Unspecified fracture of upper end of ulna

S52.001 Unspecified fracture of upper end of right ulna
S52.002 Unspecified fracture of upper end of left ulna
ICD 10 CM Documentation
Chapter Specifics

Poisoning & Adverse Effect - Same as ICD 9 CM
  - **Addition of “Underdosing”**
    - Failure in dosage during medical and surgical care (Y63.61, Y63.8-Y63.9)
    - Patient's underdosing of medication regime (Z91.12-, Z91.13-)

| Poisoning       | Overdose of substances  
<table>
<thead>
<tr>
<th></th>
<th>Wrong substance given or taken in error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse effect</td>
<td>“Hypersensitivity,” “reaction,” or correct substance properly administered</td>
</tr>
<tr>
<td>Underdosing</td>
<td>Taking less of medication than is prescribed or instructed by manufacturer either inadvertently or deliberately</td>
</tr>
</tbody>
</table>
ICD 10 CM Documentation
Chapter Specifics

Chapter 20 External Causes of Morbidity V00 – Y99

- Same guidelines as ICD 9 CM
- Causes currently located in the ICD-9-CM “E” code chapter have been disseminated to Chapter 19, Injury, Poisoning and Certain Other Consequences of External Causes, or Chapter 20, External Causes of Morbidity.
- Codes in Chapter 20 capture the cause of the injury or health condition, the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred, the activity of the patient at the time of the event, and the person’s status (i.e. civilian, military).
ICD 10 CM Documentation
Chapter Specifics

Chapter 20 External Causes of Morbidity V00 – Y99

• EXAMPLE:

• ICD-9-CM E884.0 Fall from playground equipment

ICD-10-CM W09 Fall on and from playground equipment
  W09.0   Fall on or from playground slide
  W09.1   Fall from playground swing
  W09.2   Fall on or from jungle gym
  W09.8   Fall on or from other playground equipment
Chapter 21 Factors Influencing health status Z00 – Z99

• National Center for Health Statistics data on ambulatory medical care utilization, ICD 9 CM V codes were reported as the primary reason for approximately 20 percent of all ambulatory care visits to physician offices, hospital outpatient departments, and hospital emergency departments

• Same guidelines as ICD 9 CM

• Orthopedic aftercare visit different from ICD 10 CM
ICD 10 CM Documentation
Chapter Specifics

Chapter 21 Factors Influencing health status Z00 – Z99

• Orthopedic aftercare visit different from ICD 10 CM
  – Z codes should not be used if treatment is directed at the current injury.
  – If treatment is directed at the current injury, the injury code should be reported with a seventh-character extension to identify the subsequent encounter.

• ICD-10-CM is code Z23, Encounter for immunization. This code is not further classified.

• ICD-9-CM, category codes V03, V04, V05 and V06 are used to identify the types of immunizations.
ICD 10 CM Documentation

What can you do now?

• Perform Clinical Documentation Assessments.
  – This can involve evaluating samples of various types of medical records to determine whether the documentation supports the level of detail found in ICD-10-CM.
• Documentation improvement strategies can be implemented to address areas where documentation is found to be lacking.
• Designate a physician/provider champion to assist in clinical documentation education and promote the positive aspects of moving to ICD-10-CM
• Chat with your coding staff and they will help you understand what is needed to code accurately, timely and complete
Thank you
Questions?